Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHC ON BEHALF OF
SOUTH TEXAS HEALTH SYSTEM
10002 BATTLEVIEW PARKWAY
MANASSAS VA 20109

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-08-7081-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the Stop Loss equation under Rule 134.401(c)(6), we pray for an additional payment of $25,618.44."

Amount in Dispute: $25,618.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed a twelve day IN-patient trauma hospital stay. Texas Mutual reimbursed the requester 5 days at $1,676.00 ICU/CCU trauma per diem rate and 7 days surgical trauma per diem rate of $1,234.00. The requestor billed with trauma ICD9 code 806.26. Texas Mutual also paid a fair and reasonable reimbursement for the implants. The requestor did not submit a copy of the invoices from the supplier. Remaining charges allowed at 80.25% per trauma code 806/26." "The requestor failed to provide any information to support the amount paid by Texas Mutual is NOT fair or reasonable." "The requestor, on the other hand, has failed to submit any information to support its billing of $207,188.00 is either fair or reasonable for the service provided."

Response Submitted by: Linda Estrada, Texas Mutual Insurance Co., 6210 East Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2007 through October 31, 2007	Inpatient Services	$25,618.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on August 1, 2008.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 426-Reimbursed to fair and reasonable.
   - 719-Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data submitted.
   - 891-The insurance company is reducing or denying payment after reconsideration.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 878-Duplicate appeal.
   - CAC-62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - 797-Denied for lack of preauthorization or preauthorization denial in in accordance with the network contract. [sic]

Findings

1. The respondent denied reimbursement for the disputed services based upon "CAC-62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization," and "797-Denied for lack of preauthorization or preauthorization denial in in accordance with the network contract". [sic] The Division finds that on the reconsideration EOBs, the respondent did not maintain these denial reasons; therefore, a preauthorization issue does not exist and the disputed service will be reviewed in accordance with applicable Division rules and fee guidelines.
2. The Respondent denied reimbursement based upon "878-Duplicate appeal". The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 806.26. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "Based on the Stop Loss equation under Rule 134.401(c)(6), we pray for an additional payment of $25,618.44." Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC

§134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.

5. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Based on the Stop Loss equation under Rule 134.401(c)(6), we pray for an additional payment of $25,618.44."
   - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
   - The requestor does not discuss or explain how additional payment of $25,618.44 would result in a fair and reasonable reimbursement
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/26/2011 Date
Signature	Medical Fee Dispute Resolution Manager	09/26/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.